

Individual-Level Intervention Form

Vendor Name _____

Project Name _____

Project Code _____

Facilitator Name _____

Session Date					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year			

Start Time		End Time	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hour	Minutes	Hour	Minutes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
AM	PM	AM	PM

Client Information:

Date of Birth:				Last 4 digits of SS#			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year					

Gender:

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female
<input type="checkbox"/>	Transgender
<input type="checkbox"/>	Male to Female
<input type="checkbox"/>	Female to Male
<input type="checkbox"/>	Unknown

Ethnicity:

<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	Not Hispanic

Race: (Mark all that apply)

<input type="checkbox"/>	African American or Black
<input type="checkbox"/>	American Indian or Native Alaskan
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian or other Pacific Islander
<input type="checkbox"/>	White
<input type="checkbox"/>	Other (specify) _____

Client Disposition:

Type of Appointment (Check only one)

<input type="checkbox"/>	First Appointment
<input type="checkbox"/>	Continuing Appointment
<input type="checkbox"/>	Final Appointment

Scheduling of Appointment (Check only one)

<input type="checkbox"/>	Client came for a scheduled appointment
<input type="checkbox"/>	Client came for an unscheduled visit (drop in)

Referral for Appointment (Check only one)

<input type="checkbox"/>	Client was referred by internal source (specify) _____
<input type="checkbox"/>	Client was referred by external agency (specify) _____
<input type="checkbox"/>	Client was referred by a friend or relative
<input type="checkbox"/>	Client was referred from a Group-Level Intervention
<input type="checkbox"/>	Other (specify) _____

Intervention Location:

Site Name _____

Street Address _____

City of Intervention _____

ZIP Code of Intervention _____

County of Intervention _____

(If Baltimore City, write Baltimore City)

Intervention Content:

Curriculum:

Which curriculum did you use for this session? _____

Which module(s) from the curriculum did you complete during this session?

Intervention Methods: (Mark all that apply)

- ☐ Assessment/Planning
- ☐ Prevention Education
- ☐ Skills Practice
- ☐ Risk Reduction Counseling
- ☐ Case Management
- ☐ Advocacy
- ☐ Other (specify) _____

Language of Session:

- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Other (specify) _____

Topics Discussed: (Mark up to three main topics)

- | | |
|--|--|
| <input type="checkbox"/> Knowledge: General HIV Knowledge | <input type="checkbox"/> Skills: Communication/Negotiation/Refusal |
| <input type="checkbox"/> Knowledge: HIV Services Information
(CTS, drug treatment referrals, etc) | <input type="checkbox"/> Skills: Condoms - Mechanical Skills |
| <input type="checkbox"/> Knowledge: Sexually Transmitted Diseases | <input type="checkbox"/> Skills: Needles/Works - Mechanical skills |
| <input type="checkbox"/> Knowledge: Personalizing HIV Risk
and Risk Reduction | <input type="checkbox"/> Skills: Communication for HIV Outreach/Education |
| <input type="checkbox"/> Attitudes Towards Condoms | <input type="checkbox"/> HIV Status Disclosure Issues |
| <input type="checkbox"/> Attitudes Towards Substance Use | <input type="checkbox"/> Mental/Emotional Health (depression,self-esteem,etc.) |
| <input type="checkbox"/> Peer or Social Norms for Risk Reduction | <input type="checkbox"/> General Wellness and health promotion |
| | <input type="checkbox"/> Other (please briefly describe)
_____ |

Referral Information: (Mark all that apply)

- Health**
- ☐ HIV Counseling & Testing
 - ☐ HIV Treatment
 - ☐ STD Screening/Treatment
 - ☐ Drug/Alcohol Treatment
 - ☐ Needle Exchange
 - ☐ Mental Health Services
 - ☐ Reproductive Health Services
 - ☐ Group-level HIV Prevention
 - ☐ Prevention Case Management

- Other**
- ☐ Support Group (specify type _____)
 - ☐ Counseling - Group
 - ☐ Counseling - Individual
 - ☐ Educational
 - ☐ Employment/Job Skills
 - ☐ Domestic Violence
 - ☐ Housing
 - ☐ Legal
 - ☐ Other (specify) _____

☐ Check here if this client was tested for HIV as part of this session.

Follow-up information on referrals made in previous sessions:

Previous Referral

Status

_____	<input type="checkbox"/> Completed	<input type="checkbox"/> Not Completed	<input type="checkbox"/> Status Unknown
_____	<input type="checkbox"/> Completed	<input type="checkbox"/> Not Completed	<input type="checkbox"/> Status Unknown
_____	<input type="checkbox"/> Completed	<input type="checkbox"/> Not Completed	<input type="checkbox"/> Status Unknown
_____	<input type="checkbox"/> Completed	<input type="checkbox"/> Not Completed	<input type="checkbox"/> Status Unknown
_____	<input type="checkbox"/> Completed	<input type="checkbox"/> Not Completed	<input type="checkbox"/> Status Unknown

Readiness for Change:

☐ Not assessed

What is the main risk behavior assessed below: _____

Client is currently taking measures to decrease risk for HIV infection/transmission.

☐ YES ☐ NO If YES, stop here. If NO, continue to next question.

Client plans to take measures to decrease HIV infection/transmission risk in the next month.

☐ YES ☐ NO If YES, stop here. If NO, continue to next question.

Client is seriously considering measures to decrease HIV infection/transmission in the next 6 months.

☐ YES ☐ NO

Notes or Additional Comments:
